Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NALINI NAIK MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name

TRAVELERS INDEMNITY CO OF AMERICA

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-1701-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is alleging entitlement to additional reimbursement for evaluation of additional body areas. The Carrier has reviewed the Provider's submitted documentation. The documentation supports that the Provider performed the evaluations of four body areas. Rule 134.202(e)(6)(D)(iii) states, however, that the 'examining doctor may bill for a maximum of three body areas.' As the Provider has already been reimbursed for three body areas, no additional reimbursement is due. The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers Indemnity Co., 1501 S. Mopac Expressway, Suite A-320-Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated September 23, 2011
   - FEES – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. BASED ON MAX ALLOWABLE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $1,100.00 for CPT code 99456-W5-WP with 4 (four) units in Box 24G of the CMS-1500 for a Division ordered Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the EES14 and DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR).

   28 Texas Administrative Code §134.204(j)(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and

   (III) lower extremities including feet).
2. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the narrative documentation submitted supports that MMI was assigned and 3 body areas were rated. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the MAR per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(a) for the 1st musculoskeletal area using Range of Motion (ROM) on the right shoulder (upper extremities) is $300.00, the 2nd musculoskeletal area on the left foot/ankle and buttocks (lower extremities) is $150.00 and the 3rd musculoskeletal area on the cervical/lumbar spine(spine) is $150.00. The requestor also billed for the "head", however, no documentation was found to support what services were provided specific to the "head". The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is $950.00.
3. The respondent has previously reimbursed the amount of $950.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 26, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.